RHODE ISLAND DEPARTMENT OF HEALTH
Application for Health Plan Certification / Re-certification*

Name of health plan applicant: _____

Total Rhode Island health plan enrollment: _____

☐ **Application for new certification** ☐ **Application for re-certification, if so:**

Current certificate #: _____

Name of health care entity: _____

d/b/a in Rhode Island: _____

Name of health plan's President/C.E.O.: _____

Application contact: _____ **Title:** _____

Application address: _____

Phone: (____) _____ **FAX:** (____) _____

Applicant E-mail address: _____

Billing contact: _____ **Title:** _____

Billing address: _____

Phone: (____) _____ **FAX:** (____) _____

Billing E-mail address: _____

Ownership of health care entity:

☐ **Individual** ☐ **Partnership** ☐ **Corporation**

Provide a list with the names and addresses of all direct and indirect owners whether individual, partnership or corporation with percent ownership. The list shall also include all officers, directors, and other persons of any subsidiary corporation owning stock, if the health care entity is organized as a corporation or all partners, if the health care entity is organized as a partnership.

Brief description of health plan:
Provide a description of the type/structure of the health plan (e.g., discounted fee-for-service, ASO, PPO, HMO, etc.); services/benefits provided & to whom (describe population); risk-sharing arrangements with providers; and any financial incentives available to enrollees:

Does health plan perform its own utilization review? ☐ **Yes** ☐ **No**
If no, provide a signed copy of the delegation contracts/agreements for each agency that performs utilization review for the health plan.

Are any other health plan services contracted out, carved out, or delegated to another organization? ☐ **Yes** ☐ **No**
If yes, provide a signed copy of the delegation contracts/agreements for each health plan service that is delegated (e.g., mental health, substance abuse, pharmacy, vision, dental, etc.).

All supporting documents are required in accordance with the *Health Plan Application Guidelines*:

- **I. Application Information for Each Health Plan Applicant: TAB A**
- **II. Consumer Disclosure Information: TAB B**
- **III. Policies and Procedures: TAB C - J**
- **IV. Contract Elements: TAB K**

Please enclose the non-refundable health plan application fee of $500 made payable by check to the "General Treasurer, State of Rhode Island."

I hereby submit this application with the attached *Assurances* and supporting documents, as required under RIGL 23-17.13, which contain true and accurate information to the best of my knowledge and belief.

Signature of person authorized by the health plan to submit this application:

Signature: _____

Title: _____ **Date:** _____

State of (.....)
County of (.....)
In....., in said county on this.....day of.....A.D. 20....., personally appeared before me..... Of..... who, after signing the foregoing ownership report in my presence, made oath that the facts stated in said report are true.

NOTARY PUBLIC

*Please do not re-format the *Application for Health Plan Certification / Re-certification* form.

Revised May 2004